The Commonwealth of Massachusetts
Center for Health Information and Analysis

The Massachusetts All-Payer Claims Database

Provider File Submission Guide

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Introduction

Access to timely, accurate, and relevant data is essential to improving quality, mitigating costs, and promoting transparency and efficiency in the health care delivery system. A valuable source of data can be found in health care claims but it is currently collected by a variety of government entities in various formats and levels of completeness. Using its broad authority to collect health care data ("without limitation") under M.G.L. c. 118G, § 6 and 6A, the Center for Health Information and Analysis (CHIA) has adopted regulations to create a comprehensive all payer claims database (APCD) with medical, pharmacy, and dental claims as well as provider, product, and member eligibility information derived from fully-insured, self-insured, Medicare, Medicaid and Supplemental Policy data. CHIA is a clearinghouse for comprehensive quality and cost information to ensure consumers, employers, insurers, and government have the data necessary to make prudent health care purchasing decisions.

To facilitate communication and collaboration, CHIA maintains a dedicated MA APCD website (www.mass.gov/chia/apcd) with resources that currently include the submission and release regulations, Administrative Bulletins, the technical submission guide with examples, and support documentation. These resources will be periodically updated with materials and the CHIA staff will continue to work with all affected submitters to ensure full compliance with the regulation.

While CHIA is committed to establishing and maintaining an APCD that promotes transparency, improves health care quality, and mitigates health care costs, we welcome your ongoing suggestions for revising reporting requirements that facilitate our shared goal of administrative simplification. If you have any questions regarding the regulations or technical specifications we encourage you to utilize the online resources and reach out to our staff for any further questions.

Thank you for your partnership with CHIA on the all payer claims database.

114.5 CMR 21.00 – Health Care Claims

114.5 CMR 21.00 governs the reporting requirements for Health Care Payers to submit data and information to CHIA in accordance with M.G.L. c. 118G, § 6. The regulation establishes the data submission requirements for health care payers to submit information concerning the costs and utilization of health care in Massachusetts. CHIA will collect data essential for the continued monitoring of health care cost trends, minimize the duplication of data submissions by payers to state entities, and to promote administrative simplification among state entities in Massachusetts.

Health care data and information submitted by Health Care Payers to CHIA is not a public record. No public disclosure of any health plan information or data shall be made unless specifically authorized under 114.5 CMR 21.00 or 114.5 CMR 22.00.

Acronyms Frequently Used

APCD – All-Payer Claims Database

CHIA – Center for Health Information and Analysis

CSO – Computer Services Organization

DBA – Delegated Benefit Administrator

DBM – Dental Benefit Manager

DOI – Division of Insurance

GIC – Group Insurance Commission

ID – Identification; Identifier

MA APCD – Massachusetts' All-Payer Claims Database

PBM – Pharmacy Benefit Manager

QA – Quality Assurance

RA – Risk Adjustment; Risk Adjuster

TME / RP – Total Medical Expense / Relative Pricing

TPA – Third Party Administrator

<u>The File Types:</u>

DC – Dental Claims

MC – Medical Claims

ME – Member Eligibility

PC – Pharmacy Claims

PR – Product File

PV – Provider File

The APCD Monthly Provider File

As part of the MA APCD 2013 filings, carriers will be required to submit a Provider file. CHIA recognizes that this is a file type that is currently requested of carriers in other states, and has made efforts to simplify the data submission and clarify the elements collected within it, and its usage by CHIA and agency partners using the MA APCD.

Below we have provided details on business rules, data definitions and the potential uses of this data.

Specification Question	Clarification	Rationale
Frequency of submission	Monthly	CHIA requires monthly submission of this file to insure matching algorithms and reporting requirements of TME / RP.
What is the format of the file	Each submission must be a variable field length asterisk delimited file	An asterisk cannot be used within an element in lieu of another character. Example: if the file includes "Smith*Jones" in the Last Name, the system will read an incorrect number of elements and drop the file.
What each row in file equals	A unique instance of a provider entity, and that provider's affiliation to another entity, or a provider's affiliation to a specific location.	CHIA is required to analyze information on providers, clinicians, hospitals, physician groups and integrated delivery systems for the purposes of standardization and reporting.
How the Division defines a provider	A provider is an entity associated with either: 1. providing services to patients 2. submitting claims for services on behalf of a servicing provider 3. providing business services or contracting arrangements for a servicing provider	CHIA analyzes information on providers, clinicians, hospitals, physician groups and integrated delivery systems.

How a unique provider is to be defined	Conceptually, a unique provider is an instance of a provider (Who), with a particular affiliation (Relationship), at a particular location (where), during a pre-defined timeframe (when). The Division will utilize multiple data elements to create a unique provider record within each carrier file.	CHIA realizes that submitters store their provider data in a variety of formats and data structures. It has been determined that this method provides the greatest flexibility in analyzing the various ways submitters maintain provider relationships.
Types of providers to be included in the file	All Massachusetts contracted providers, regardless of whether they are on the claims file for the time period. Additionally, provider information for out of state providers, who are on the claims file for the time period of the corresponding claims submission – If available. Otherwise use default values as provided in the document: "Provider File Examples.xls".	CHIA is required to create a cross-submitter provider files for analysis and therefore requires data on all providers in a carrier's or submitter's network. Additionally, all claims may be analyzed by provider dimensions that require provider information for corresponding out of state claims.
Reporting time period and providers to be included on the file	All providers, both active and non-active. Providers that were inactive prior to January 2008 do not need to be included. It is necessary to report any and all provider information that aligns to the eligibility and claims data to insure that linking between files can occur.	CHIA collects the most up to date provider data that can be used to analyze claims data. Since claims data is collected monthly, the provider file can be synced with the claims file, and can be a snapshot of how the provider file looked at the end of the period for which claims are sent.

Types of Data being collected in the provider file

Provider Identifiers

CHIA has made a conscious decision to collect numerous identifiers that may be associated with a provider. The data in elements PV002 through PV008, PV035, PV036, PV039, and PV040 (described below in the data dictionary) will be used by CHIA to create a Master Provider Data Set for analyzing providers across submitters. The identifiers will be used to help link providers across carriers in the event that the primary linking data elements are not a complete match. The existence of these extra identifying elements will improve the quality of our matching algorithms.

Demographics

CHIA is collecting address information on each provider entity in order to meet reporting and analysis requirements of the MA APCD. Additional demographic data elements such as Gender and Date of Birth for the individual provider are being collected mainly for use creating the Master Provider Data Set for linking across carriers without personal identifiers. These two elements will be used, when provided, to help with the quality of the matching algorithms.

Provider Specialty

The elements Taxonomy, Provider Type Code, and Provider Specialty are required elements and will be used to meet reporting and analysis requirements of the APCD including clinical groupings and provider specific reports. Each submitter must submit its internal code sets (lookup tables) to CHIA for PV042 thru PV044 if using codes or values that are not cited as the standard used by the MA APCD, else submitters may use the standard across all Specialty elements.

Dates

CHIA is collecting two sets of date elements for each provider record. The Begin and End date for each provider describes the dates the provider is active with the carrier and is eligible to provide services to members. For providers who are still active the End date should be Null. The Provider Affiliation Start and Provider Affiliation End Date describe the providers' affiliation/association with a parent entity, such as a billing entity, corporate entity, doctor's office, provider group, or integrated delivery system. Each unique instance of these start and end dates should be submitted as a separate record on this file. If a provider was active and termed in the past with the carrier, and was added back as an active provider, each instance of those 'active' dates should be provided, one for each time span. Similarly, each instance of a provider affiliation, and those associated dates should be provided in a record. If a provider has always been active with a carrier since 2008, but has changed affiliations once, there would be two records submitted as well, one for each affiliation and those respective dates. If a provider's affiliation is

terminated, and is made active again at a later date, this would require two records as well.

Qualifiers

CHIA is collecting provider information related to healthcare reform, electronic health records, patient centered medical home, TME/RP, and DOI reporting. These data elements may or may not currently be captured in a submitter's core systems and may require additional coding to extract it from periphery applications to populate the elements for MA APCD. It is CHIA's responsibility to collect these elements under Administrative Simplification.

Examples

1. Individual Provider practicing within one doctor's office or group and only one physical office location.

A provider fitting this description should have 1 record per active time span. The record would contain information about the provider (Dr. Jones) and the affiliation elements would indicate that Dr. Jones practices or contracts with (ABC Medical). ABC Medical, since it is a group, would have its own separate record as well in this file. A physician assistant or nurse working in the doctor's office should also be submitted, under their own unique record.

2. Individual Provider practicing within an office they own.

A provider fitting this description should have 1 record per active time span for their individual information (Dr. Jones) and a second record for their practice, Dr. Jones Family Care. A physician assistant or nurse working in the doctor's office should also be submitted, under their own unique record.

3. Individual Provider practicing within an office they own or for a practice they do not own across two physical locations.

A provider fitting this description should have 2 records per active time span. The office, affiliation or entity that the doctor does business under (ABC Medical, Dr. Jones family medicine) would have only 1 additional record.

4. Individual Provider practicing across two groups or different affiliations.

A provider fitting this description should have 2 records per active time span, one for each group/entity they are affiliated with. Each group/entity would have its own separate record as well.

5. Entity, Group or Office in one location

An entity fitting this description should have one record per active time span. All affiliated entities, or providers that could be linked or rolled up to these entities, groups or offices, would each have their own records.

6. Entity, Group or Office in two locations

An entity fitting this description should have two records per active time span, one for each location. . All affiliated entities, or providers that could be linked or rolled up to these entities, groups or offices, would each have their own records. If these affiliated entities and providers are associated with just one of the locations, they would have one corresponding record. If they are affiliated with each of the parent entity's locations, they should have one record for each location, similar to example 3.

7. Billing organizations

An entity that shows up in the claims file in the Billing Provider element should also have a corresponding provider record. Medical Billing Associates, Inc. should have one record for each location and identifier it bills under as determined by the claims file.

8. Integrated Delivery Systems

Each of these types of organizations should have their own record if the carrier has a contract with those entities. All entities, groups or providers affiliated with the Organization should have the Provider ID of this entity in the Provider Affiliation element. Entities meeting a description similar to an Integrated Delivery System should show up one time in the provider file.

The Provider ID

The goal of element PV002 is to help identify provider data elements associated with the providers identified in the claim line detail, and to identify the details of the Provider Affiliation, when applicable. A Provider ID itself may or may not be unique on this file – but in combination with the Provider Affiliation (PV056) – the two together must be unique for a given time period.

The Provider ID is a unique number for every service provider (persons, facilities or other entities involved in claims transactions) that a carrier has in its system. This element may or may not be the provider NPI and this element is used to uniquely identify a provider and that provider's affiliation, when applicable as well as the provider's practice location within this provider file.

The following are the elements that are required to link to PV002:
Provider File Link: PV056 – Provider Affiliation;

Member Eligibility Links: ME036 – Health Care Home ID; **ME046** – Member PCP ID;

Medical Claim Links: MC024 – Service Provider Number; **MC076** – Billing Provider Number; **MC112** – Referring Provider ID; **MC125** – Attending Provider; **MC134** – Plan Rendering Provider Identifier; **MC135** – Provider Location;

Pharmacy Claim Links: PC043 – Prescribing Provider ID; **PC059** – Recipient PCP ID;

Dental Claim Link: DC018 – Service Provider Number

Loading a record where PV002 = PV056 establishes a base record for a provider. All other instances of that PV002 value represent affiliations or additional locations for a provider. See the "Provider File Examples.xls" document for sample data.

New Data Elements

Under Administrative Simplification, CHIA has worked with Division of Insurance, The Connector, Group Insurance Commission and our own internal departments to identify new elements to be added to the MA APCD Dataset to satisfy that goal. Below is a list of those elements, the submitter type expected to report them, the reason and the data expected within the element.

HD009 – APCD Version #; *all submitters, required for setting intake edits*

This new Header element requires the version number of the MA APCD Specifications that a submitter is using to compile their ME File. Current version is 3.0, prior version is 2.1

PV031 – Provider Organization ID; *all TME submitters, required for provider non-claims payment attribution*

This new element applies the Local Practice Group OrgID used to identify Providers in TME reporting to the MA APCD Data Set. It is required for aggregation of various other elements of the PV File in tandem with the Eligibility File. A list of these OrgIDs can be found on the TME / RP website titled TME Provider OrgID List:

http://www.mass.gov/chia/researcher/health-care-delivery/hcf-data-resources/total-medical-expenses-relative-price/total-medical-expenses-filing-information.html

PV032 – Payment Arrangement Type; *all TME submitters, required for provider non-claim payment attribution*

This new element for the PV File is currently collected on all the Claims Files. This lookup table element allows for the various payment methodologies to be applied to the providers identified in PV031. Non-TME reporters may report information in this element, but must follow the submission guidelines for content and quality.

PV065 thru PV070 all pertain to Total Medical Expense (TME) Reporting and are required of those submitters that are currently responsible to report TME Data to CHIA. Please review each of these elements to understand the requirements and conditions applied. Non-TME reporters may report information in these elements, but must follow the submission guidelines for content and quality.

To identify if your organization is a TME / RP reporter and required to submit the additional data elements, please review the list of TME Filing OrgIDs on the TME / RP websites:

http://www.mass.gov/chia/researcher/health-care-delivery/hcf-data-resources/total-medical-expenses-relative-price/list-of-payers-required-to-report-data.html

File Guideline and Layout

Legend

1. File: Identifies the file per element as well as the Header and Trailer Records that repeat on all MA APCD File Types. Headers and Trailers are Mandatory as a whole, with just a few elements allowing situational reporting.
2. Col: Identifies the column the data resides in when reported
3. Elmt: This is the number of the element in regards to the file type
4. Date Element Name: Provides identification of basic data required
5. Date Modified: Identifies the last date that an element was adjusted
6. Type: Defines the data as Decimal, Integer, Numeric or Text. Additional information provided for identification, e.g., Date Period – Integer
7. Type Description: Used to group like-items together for quick identification
8. Format / Length: Defines both the reporting length and element min/max requirements. See below:
    a. char[n] – this is a fixed length element of [n] characters, cannot report below or above [n]. This can be any type of data, but is governed by the type listed for the element, Text vs. Numeric.
    b. varchar[n] – this is a variable length field of max [n] characters, cannot report above [n]. This can be any type of data, but is governed by the type listed for the element, Text vs. Numeric.
    c. int[n] – this is a fixed type and length element of [n] for numeric reporting only. This cannot be anything but numeric with no decimal points or leading zeros.

    The plus/minus symbol (±) in front on any of the Formats above indicate that a negative can be submitted in the element under specific conditions. **Example:** When the Claim Line Type (MC138) = V (void) or B (backout) then certain claim values can be negative.
9. Description: Short description that defines the data expected in the element
10. Element Submission Guideline: Provides detailed information regarding the data required as well as constraints, exceptions and examples.
11. Condition: Provides the condition for reporting the given data
12. %: Provides the base percentage that the MA APCD is expecting in volume of data in regards to condition requirements.
13. Cat: Provides the category or tiering of elements and reporting margins where applicable.

Elements that are highlighted indicate that a MA APCD lookup table is present and contains valid values expected in the element. In very few cases, there is a combination of a MA APCD lookup table and an External Code Source or Carrier Defined Table, these maintain the highlight.

It is important to note that Type, Format/Length, Condition, Threshold and Category are considered as a suite of requirements that the intake edits are built around to insure compliance, continuity and quality. This insures that the data can be standardized at other levels for greater understanding of healthcare utilization.

File	Col	Elmt	Data Element Name	Date Modified	Type	Type Description	Format / Length	Description	Element Submission Guideline	Condition	%	Cat
HD -PV	1	HD 001	Record Type	11/8/12	Text	ID Record	char[2]	Header Record Identifier	Report **HD** here. Indicates the beginning of the Header Elements of the file	Mandatory	100%	HM
HD -PV	2	HD 002	Submitter	11/8/12	Integer	ID OrgID	varchar[6]	Header Submitter / Carrier ID defined by CHIA	Report CHIA defined, unique Submitter ID here. TR002 must match the Submitter ID reported here. This ID is linked to other elements in the file for quality control	Mandatory	100%	HM
HD -PV	3	HD 003	National Plan ID	11/8/12	Integer	ID Nat'l PlanID	int[10]	Header CMS National Plan Identification Number (PlanID)	Do not report any value here until National PlanID is fully implemented. This is a unique identifier as outlined by Centers for Medicare and Medicaid Services (CMS) for Plans or Sub plans	Situational	0%	HS
HD -PV	4	HD 004	Type of File	11/8/12	Text	ID File	char[2]	Defines the file type and data expected.	Report **PV** here. Indicates that the data within this file is expected to be PROVIDER-based. This must match the File Type reported in TR004	Mandatory	100%	HM
HD -PV	5	HD 005	Period Beginning Date	11/8/12	Date Period - Integer	Century Year Month - CCYYMM	int[6]	Header Period Start Date	Report the Year and Month of the reported submission period in CCYYMM format. This date period must be repeated in HD006, TR005 and TR006. This same date must be selected in the upload application for successful transfer.	Mandatory	100%	HM
HD -PV	6	HD 006	Period Ending Date	11/8/12	Date Period - Integer	Century Year Month - CCYYMM	int[6]	Header Period Ending Date	Report the Year and Month of the reporting submission period in CCYYMM format. This date period must match the date period reported in HD005 and be repeated in TR005 and TR006	Mandatory	100%	HM

HD -PV	7	HD 007	Record Count	11/8/12	Integer	Counter	varchar[10]	Header Record Count	Report the total number of records submitted within this file. Do not report leading zeros, space fill, decimals, or any special characters.	Mandatory	100%	HM
HD -PV	8	HD 008	Comments	11/8/12	Text	Free Text Field	varchar[80]	Header Carrier Comments	May be used to document the submission by assigning a filename, system source, compile identifier, etc.	Optional	0%	HO
HD -PV	9	HD 009	APCD Version Number	11/8/12	Decimal - Numeric	ID Version	char[3]	Submission Guide Version	Report the version number as presented on the APCD Provider File Submission Guide in 0.0 Format. Sets the intake control for editing elements. Version must be accurate else file will drop. **EXAMPLE:** 3.0 = Newest Version	Mandatory	100%	HM
								Code	***Description***			
								2.1	Prior Version; valid only for reporting periods prior to May 2013			
								3.0	Current Version; required for reporting periods as of May 2013			
PV	1	PV 001	Submitter	11/8/12	Integer	ID Submitter	varchar[6]	CHIA defined and maintained unique identifier	Report the Unique Submitter ID as defined by CHIA here. This must match the Submitter ID reported in HD002	All	100%	A0
PV	2	PV 002	Plan Provider ID	12/1/10	Text	ID Link to PV056, ME036, ME046 MC024, MC076, MC112, MC125, MC134, MC135, PC043, PC059, DC018	varchar[30]	Carrier Unique Provider Code	Report the submitter assigned unique number for every service provider (persons, facilities or other entities involved in claims transactions) that it has in its system(s). This element may or may not contain the provider NPI, but should not contain an individual's SSN	All	100%	A0
PV	3	PV 003	Tax Id	11/8/12	Numeric	ID Tax	char[9]	Federal Tax ID of non-individual Provider	Report the Federal Tax ID of the Provider here. Do not use hyphen or alpha prefix.	Required when PV034 = 2, 3, 4, 5, 6, 7, or 0	98%	A2
PV	4	PV 004	UPIN Id	11/8/12	Text	ID Medicare	char[6]	Unique Physician ID	Report the UPIN for the Provider identified in PV002. To report other Medicare Identifiers use PV036	Required when PV034 = 1	98%	B
PV	5	PV 005	DEA ID	11/8/12	Text	ID DEA	char[9]	Provider DEA	Report the valid DEA ID of the individual, group or facility defined by PV002. If not available or	Required when PV034 = 0,	98%	B

									applicable, do not report any value here.	1, 2, 3, 4, or 5		
PV	6	PV 006	License Id	11/8/12	Text	ID License	varchar[25]	State practice license ID	Report the state license number for the provider identified in PV002. For a doctor this is the medical license for a non-doctor this is the practice license. Do not use zero-fill. If not available, or not applicable, such as for a group or corporate entity, do not report any value here.	All	98%	B
PV	7	PV 007	Medicaid Id	11/8/12	Text	ID MassHealth	varchar[25]	MassHealth-assigned Provider ID	Report the Massachusetts State Medicaid number for the provider identified in PV002. Do not use zero-fill. Do not report any value if not available, or not applicable, such as for a group or corporate entity.	All	98%	B
PV	8	PV 008	Last Name	11/8/12	Text	Name Last Provider	varchar[50]	Last name of the Provider in PV002	Report the individual's last name here. Do not report any value here for facility or non-individual provider records. Report non-person entities in PV012 Facility Name	Required when PV034 = 1	98%	A0
PV	9	PV 009	First Name	11/8/12	Text	Name First Provider	varchar[50]	First name of the Provider in PV002	Report the individual's first name here. Do not report any value here for facility or non-individual provider records. Report non-person entities in PV012 Facility Name	Required when PV034 = 1	98%	A2
PV	10	PV 010	Middle Initial	11/8/12	Text	Name Middle Provider	char[1]	Middle initial of the Provider in PV002	Report the individual's middle initial here. Do not report any value here for facility or non-individual provider records. Report non-person entities in PV012 Facility Name	Required when PV034 = 1	1%	C
PV	11	PV 011	Suffix	11/8/12	Lookup Table - Integer	tlkpLastNameSuffix	int[1]	Suffix of the Provider in PV002	Report the individual's name suffix here. Do not report any value here for facility or non-individual provider records. Report non-person entities in PV012 Facility Name. **EXAMPLE:** 0 = Unknown / Not Applicable	Required when PV034 = 1	1%	Z

Value	***Description***
1	I.
2	II.
3	III.

								4	Jr.			
								5	Sr.			
								0	Unknown / Not Applicable			
PV	12	PV 012	Entity Name	11/8/12	Text	Name Provider Entity	varchar[100]	Group / Facility name	Report the Provider Entity Name when Punctuation may be included. This should only be populated for facilities or groups.	Required when PV034 = 2, 3, 4, 5, 6, 7, or 0	98%	A1
PV	13	PV 013	Entity Code	11/8/12	Lookup Table - Text	tlkpEntityCode	char[2]	Provider facility code	Report the value that defines the entity provider type. **EXAMPLE:** 12 = Acute Hospital	Required when PV034 does not = 1	98%	A0
								Value	***Description***			
								01	Academic Institution			
								02	Adult Foster Care			
								03	Ambulance Services			
								04	Hospital Based Clinic			
								05	Stand-Alone, Walk-In/Urgent Care Clinic			
								06	Other Clinic			
								07	Community Health Center - General			
								08	Community Health Center - Urgent Care			
								09	Government Agency			
								10	Health Care Corporation			
								11	Home Health Agency			
								12	Acute Hospital			
								13	Chronic Hospital			
								14	Rehabilitation Hospital			
								15	Psychiatric Hospital			
								16	DPH Hospital			
								17	State Hospital			

								18	Veterans Hospital			
								19	DMH Hospital			
								20	Sub-Acute Hospital			
								21	Licensed Hospital Satellite Emergency Facility			
								22	Hospital Emergency Center			
								23	Nursing Home			
								24	Freestanding Ambulatory Surgery Center			
								25	Hospital Licensed Ambulatory Surgery Center			
								26	Non-Health Corporations			
								27	School Based Health Center			
								28	Rest Home			
								29	Licensed Hospital Satellite Facility			
								30	Hospital Licensed Health Center			
								31	Other Facility			
								40	Physician (PV034 = 1)			
								50	Physician Group (PV034 = 3)			
								60	Nurse (PV034 = 1)			
								70	Clinician (PV034 = 1)			
								80	Technician (PV034 = 1)			
								90	Pharmacy / Site or Mail Order (PV034 = 4 or 5)			
								99	Other Individual or Group (PV034 = 1 or 3)			
PV	14	PV 014	Gender Code	11/8/12	Lookup Table - Text	tlkpGender	char[1]	Gender of Provider identified in PV002	Report provider gender in alpha format as found on certification, contract and / or license.	Required when PV034 = 1	98%	B
								Code	***Description***			
								F	Female			
								M	Male			

								O	Other			
								U	Unknown			
PV	15	PV 015	DOB Date	11/8/12	Full Date - Integer	Century Year Month Day - CCYYMMDD	int[8]	Provider's date of birth	Report the individual's data of birth in CCYYMMDD Format. Only applies to providers identified as Entity = Person. Do not report any value here for non-person entities, e.g. Professional Groups, Medical Sites.	Required when PV034 = 1	98%	B
PV	16	PV 016	Provider Street Address 1	11/8/12	Text	Address 1 Provider	varchar[50]	Street address of the Provider	Report the physical street address where provider sees plan members. If only mailing address is available, please send the mailing address in this element in addition to putting it in the mailing address element . If the provider sees members at two locations the provider should have a unique record for each to capture each site where the provider practices.	All	98%	A1
PV	17	PV 017	Provider Street Address 2	11/8/12	Text	Address 2 Provider	varchar[50]	Street Address 2 of the Provider	Report the physical street address where provider sees plan members. If only mailing address is available, please send the mailing address in this element in addition to putting it in the mailing address element. If the provider sees members at two locations the provider should have a unique record for each to capture each site where the provider practices.	All	2%	A0
PV	18	PV 018	City Name	6/24/10	Text	Address City Provider	varchar[35]	City of the Provider	Report the city name where provider sees plan members. If only mailing address is available, please send the mailing address in this element in addition to putting it in the mailing address element. If the provider sees members at two locations the provider should have a unique record for each to capture each site where the provider practices.	All	98%	A1

PV	19	PV 019	State Code	11/8/12	External Code Source 2 - Text	Address State External Code Source 2 - States	char[2]	State of the Provider	Report the state of the site in which the provider sees plan members. When only a mailing address is available, populate with mailing state here as well as PV026. When a provider sees patients at two or more locations, the provider should have a unique record for each location to capture all possible practice sites.	All	98%	A0
PV	20	PV 020	Country Code	12/1/10	External Code Source 1 - Text	Address Country External Code Source 1 - Countries	char[3]	Country Code of the Provider	Report the three-character country code as defined by ISO 3166-1, Alpha 3	All	98%	C
PV	21	PV 021	Zip Code	11/8/12	External Code Source 2 - Text	Address Zip External Code Source 2 - Zip Codes	varchar[9]	Zip code of the Provider	Report the 5 or 9 digit Zip Code as defined by the United States Postal Service. When submitting the 9-digit Zip Code do not include hyphen.	All	98%	A0
PV	22	PV 022	Taxonomy	11/8/12	External Code Source 5 - Text	External Code Source 5 - Taxonomy	char[10]	Taxonomy Code	Report the standard code that defines this provider for this line of service. Taxonomy values allow for the reporting of many types of clinicians, assistants and technicians, where applicable, as well as Physicians, Nurses, Groups, Facilities, etc.	Required when PV034 = 0, 1, 2, 3, 4, or 5	75%	C
PV	23	PV 023	Mailing Street Address1 Name	6/24/10	Text	Address 1 Provider	varchar[50]	Street address of the Provider / Entity	Report the mailing address of the Provider / Entity in PV002	All	98%	A0
PV	24	PV 024	Mailing Street Address2 Name	6/24/10	Text	Address 2 Provider	varchar[50]	Secondary Street address of the Provider / Entity	Report the mailing address of the Provider / Entity in PV002	All	2%	B
PV	25	PV 025	Mailing City Name	6/24/10	Text	Address City Provider	varchar[35]	City name of the Provider / Entity	Report the mailing city address of the Provider / Entity in PV002	All	98%	A0
PV	26	PV 026	Mailing State Code	11/8/12	External Code Source 2 - Text	Address State External Code Source 2 - States	char[2]	State name of the Provider / Entity	Report the mailing state address of the Provider / Entity in PV002	All	98%	A0

PV	27	PV 027	Mailing Country Code	12/1/10	External Code Source 1 - Text	Address Country External Code Source 1 - Countries	char[3]	Country name of the Provider / Entity	Report the three-character country code as defined by ISO 3166-1, Alpha 3	All	98%	C
PV	28	PV 028	Mailing Zip Code	11/8/12	External Code Source 2 - Text	Address Zip External Code Source 2 - Zip Codes	varchar[9]	Zip code of the Provider	Report the 5 or 9 digit Zip Code as defined by the United States Postal Service. When submitting the 9-digit Zip Code do not include hyphen.	All	98%	A0
PV	29	PV 029	Provider Type Code	6/24/10	Carrier Defined Table - Text	Carrier Defined Table - Provider Type Code	varchar[10]	Provider Type Code	Report the Provider Type code associated with the individual provider or facility. The carrier must provide the APCD with Reference tables. This element distinguishes clinicians, facilities, and other. Clinicians are physicians and other practitioners who can perform an E&M service (thereby start an episode of care). Facilities can sometimes start episodes (i.e. patient goes to ER at onset of symptoms). Providers classified as 'other' never start episodes. The APCD may use this element to perform further clinical and analytic grouping. Entities not seeing patients should have a classification of 'Other'	All	98%	A1
PV	30	PV 030	Primary Specialty Code	11/8/12	External Code Source 4 - Integer	External Code Source 4 - Specialties	int[3]	Specialty Code	Report the standard Primary Specialty code of the Provider here	Required when PV034 = 0, 1, 2, 3, 4, or 5	98%	A2
PV	31	PV 031	Provider Organization ID	11/8/12	Integer	ID OrgID	varchar[6]	CHIA defined and maintained Org ID for Providers	Report the Local Practice Group OrgID number as assigned / maintained by CHIA for Total Medical Expense (TME) reporting.	Required when Submitter is identified as a TME/RP Submitter	100%	A2
PV	32	PV 032	Payment Arrangement Type	11/8/12	Lookup Table - Numeric	tlkpPaymentArrangementType	char[2]	Payment Arrangement Type Value	Report the value that defines the contracted payment methodology for this provider. Required for TME/RP reporting. **EXAMPLE:** 02 = Fee for	Required when Submitter is identified	100%	A2

									Service	as a TME / RP Submitter		

Value	*Description*
01	Capitation
02	Fee for Service
03	Percent of Charges
04	DRG
05	Pay for Performance
06	Global Payment
07	Other
08	Bundled Payment

PV	33	PV 033	Filler	11/8/12	Filler	Filler	char[0]	Filler	The APCD reserves this element for future use. Do not populate with any data.	All	0%	Z
PV	34	PV 034	Provider ID Code	11/8/12	Lookup Table - Integer	tlkpEntityQualifier Code	int[1]	Provider Identification Code	Report the value that defines type of entity associated with PV002. The value reported here drives intake edits for quality purposes. **EXAMPLE:** 1 = Person; Physician, Clinician, Orthodontist, etc.	All	100%	A0

Value	*Description*
1	**Person**; physician, clinician, orthodontist, and any individual that is licensed/certified to perform health care services.
2	**Facility**; hospital, health center, long term care, rehabilitation and any building that is licensed to transact health care services.
3	**Professional Group**; collection of licensed/certified health care professionals that are practicing health care services under the same entity name and Federal Tax Identification Number.
4	**Retail Site**; brick-and-mortar licensed/certified place of transaction

									that is not solely a health care entity, i.e., pharmacies, independent laboratories, vision services.			
								5	**E-Site**; internet-based order/logistic system of health care services, typically in the form of durable medical equipment, pharmacy or vision services. Address assigned should be the address of the company delivering services or order fulfillment.			
								6	**Financial Parent**; financial governing body that does not perform health care services itself but directs and finances health care service entities, usually through a Board of Directors.			
								7	**Transportation**; any form of transport that conveys a patient to/from a healthcare provider			
								0	**Other**; any type of entity not otherwise defined that performs health care services.			
PV	35	PV 035	SSN Id	11/8/12	Numeric	ID Tax	char[9]	Provider's Social Security Number	Report the SSN of the individual provider in PV002. Do not zero-fill. Do not report any value here if not available or not applicable.	Required when PV034 = 1	98%	A1
PV	36	PV 036	Medicare ID	6/24/10	Text	ID Medicare	varchar[30]	Provider's Medicare Number, other than UPIN	Report the Medicare ID (OSCAR, Certification, Other, Unspecified, NSC or PIN) of the provider or entity in PV002. Do not report UPIN here, see PV004.	Required when PV034 = 0, 1, 2, 3, 4, or 5	90%	B
PV	37	PV 037	Begin Date	11/8/12	Full Date - Integer	Century Year Month Day - CCYYMMDD	int[8]	Provider Start Date	Report the date the provider or facility becomes eligible / contracted to perform services for plan members in CCYYMMDD Format. Do not report any value here for providers that do not render services.	All	98%	A2
PV	38	PV 038	End Date	11/8/12	Full Date - Integer	Century Year Month Day - CCYYMMDD	int[8]	Provider End Date	Report the Date the provider or facility is no longer eligible to perform services for plan members / insureds in CCYYMMDD Format. Do not report any value here for providers	Required when PV034 = 0, 1, 2, 3, 4, or 5	98%	B

									that are still actively eligible to provide services, or Providers who do not render services (i.e., Parent Organizations).			
PV	39	PV 039	National Provider ID	11/8/12	External Code Source 3 - Integer	External Code Source 3 - National Provider ID	int[10]	National Provider Identification (NPI) of the Provider	Report the NPI of the Provider / Clinician / Facility / Organization defined in this record	Required when PV034 = 0, 1, 2, 3, 4, or 5	98%	B
PV	40	PV 040	National Provider ID 2	11/8/12	External Code Source 3 - Integer	External Code Source 3 - National Provider ID	int[10]	National Provider Identification (NPI) of the Provider	Report the Secondary or Other NPI of the Provider / Clinician / Facility / Organization defined in this record	Required when PV034 = 0, 1, 2, 3, 4, or 5	1%	C
PV	41	PV 041	GIC Provider Link ID	11/8/12	Text	ID GIC	varchar[25]	GIC Provider Link ID for GIC Carriers only	Report the GIC Assigned Provider Link ID. If not applicable, do not report any value here	Required when Submitter is identified as a GIC Submitter	0%	B
PV	42	PV 042	Proprietary Specialty Code	11/8/12	Carrier Defined Table - Text	Carrier Defined Table - Specialty	varchar[10]	Specialty Code	Report the submitter's proprietary specialty code for the provider here. Known additional specialty code for a provider should be populated in elements PV043 and PV044. Value comes from a Carrier Defined Table only	Required when PV034 = 0, 1, 2, 3, 4, or 5	1%	B
PV	43	PV 043	Other Specialty Code 2	11/8/12	Carrier Defined Table **- OR -** External Code Source 4 - Integer	External Code Source 4 - Specialties	varchar[10]	Specialty Code	See mapping notes for primary specialty code in PV030. Known additional specialty code for a provider should be populated in this element. Value can come from either a Carrier Defined Table or the External Code Source	Required when PV034 = 0, 1, 2, 3, 4, or 5	0%	B
PV	44	PV 044	Other Specialty Code 3	11/8/12	Carrier Defined Table **- OR -** External Code Source 4 - Integer	External Code Source 4 - Specialties	varchar[10]	Specialty Code	See mapping notes for primary specialty code in PV030. Known additional specialty code for a provider should be populated in this element. Value can come from either a Carrier Defined Table or the External Code Source	Required when PV034 = 0, 1, 2, 3, 4, or 5	0%	B

PV	45	PV 045	Pay for Performance Flag	11/8/12	Lookup Table - Integer	tlkpFlagIndicators	int[1]	Indicator - Provider Contract Payment	Report the value that defines the element. Pay-for-performance bonuses or year-end withhold returns based on performance for at least one service performed by this provider within the month. **EXAMPLE:** 1 = Yes, provider has a contract incentive.	Required when PV034 = 1, 2, or 3	100%	A2
								Value	***Description***			
								1	Yes			
								2	No			
								3	Unknown			
								4	Other			
								5	Not Applicable			
PV	46	PV 046	NonClaims Flag	11/8/12	Lookup Table - Integer	tlkpFlagIndicators	int[1]	Indicator - Provider Contract Payment	Report the value that defines the element. NonClaims payments that occur at least once within the month must be reported. **EXAMPLE:** 1 = Yes, provider may be eligible to receive other payments not flowing through the claims system.	All	100%	A2
								Value	***Description***			
								1	Yes			
								2	No			
								3	Unknown			
								4	Other			
								5	Not Applicable			
PV	47	PV 047	Uses Electronic Health Records	11/8/12	Lookup Table - Integer	tlkpFlagIndicators	int[1]	Indicator - EHR Utilization	Report the value that defines the element. **EXAMPLE:** 1 = Yes, provider uses Electronic Health Records	All	100%	A2
								Value	***Description***			
								1	Yes			
								2	No			
								3	Unknown			

								4	Other			
								5	Not Applicable			
PV	48	PV 048	EHR Vendor	11/8/12	Text	Name Vendor	varchar[40]	Electronic Health Record Vendor Name	Report the name of the vendor the provider uses for EHR processing	Required when PV047 = 1	98%	B
PV	49	PV 049	Accepting New Patients	11/8/12	Lookup Table - Integer	tlkpFlagIndicators	int[1]	Indicator - New Patients Accepted	Report the value that defines the element. **EXAMPLE:** 1 = Yes, provider or provider group is accepting new patients as of the day the file was created for this submission.	Required when PV034 = 1, 2, or 3	100%	A2
								Value	***Description***			
								1	Yes			
								2	No			
								3	Unknown			
								4	Other			
								5	Not Applicable			
PV	50	PV 050	Offers e-Visits	11/8/12	Lookup Table - Integer	tlkpFlagIndicators	int[1]	Indicator - eVisit Option	Report the value that defines the element. **EXAMPLE:** 1 = Yes, provider has capacity to perform eVisits.	Required when PV034 = 1, 2, 3, or 4	100%	A2
								Value	***Description***			
								1	Yes			
								2	No			
								3	Unknown			
								4	Other			
								5	Not Applicable			
PV	51	PV 051	Filler	11/8/12	Filler	Filler	char[0]	Filler	The APCD reserves this element for future use. Do not populate with any data.	All	0%	Z
PV	52	PV 052	Has multiple offices	11/8/12	Lookup Table - Integer	tlkpFlagIndicators	int[1]	Indicator - Multiple Office Provider	Report the value that defines the element. **EXAMPLE:** 1 = Yes, provider has multiple offices.	Required when PV034 = 1, 2, or 3	100%	A0
								Value	***Description***			

								1	Yes			
								2	No			
								3	Unknown			
								4	Other			
								5	Not Applicable			
PV	53	PV 053	Filler	11/8/12	Text	Filler	char[0]	Filler	The APCD reserves this element for future use. Do not populate with any data.	All	0%	Z
PV	54	PV 054	Medical / Healthcare Home ID	6/24/10	Text	ID Link to PV002	varchar[15]	Medical Home Identification Number	Report the identifier of the patient-centered medical home the provider is linked-to here. The value in this element must have a corresponding Provider ID (PV002) in this or a previously submitted provider file.	Require when PV034 = 1, 2, or 3	0%	B
PV	55	PV 055	PCP Flag	11/8/12	Lookup Table - Integer	tlkpFlagIndicators	int[1]	Indicator - Provider is a PCP	Report the value that defines the element. **EXAMPLE:** 1 = Yes, provider is a PCP.	Required when PV034 = 1	100%	A0
								Value	***Description***			
								1	Yes			
								2	No			
								3	Unknown			
								4	Other			
								5	Not Applicable			
PV	56	PV 056	Provider Affiliation	6/24/10	Text	ID Link to PV002	varchar[30]	Provider Affiliation Code	Report the Provider ID for any affiliation the provider has with another entity or parent company. If the provider is associated only with self, record the same value here as PV002.	All	99%	B
PV	57	PV 057	Provider Telephone	6/24/10	Numeric	Telephone	varchar[10]	Telephone number associated with the provider identified in PV002	Report the telephone number of the provider associated with the identification in PV002. Do not separate components with hyphens, spaces or other special characters	All	10%	C
PV	58	PV 058	Delegated Provider Record Flag	11/8/12	Lookup Table - Integer	tlkpFlagIndicators	int[1]	Indicator - Delegated Record	Report the value that defines the element. **EXAMPLE:** 1 = Yes, provider record was sourced from the delegated provider's system.	All	100%	A2

								Value	***Description***			
								1	Yes			
								2	No			
								3	Unknown			
								4	Other			
								5	Not Applicable			
PV	59	PV 059	Filler	11/8/12	Filler	Filler	char[0]	Filler	The APCD reserves this element for future use. Do not populate with any data.	All	0%	Z
PV	60	PV 060	Office Type	11/8/12	Lookup Table - Integer	tlkpOfficeType	int[1]	Office Type Code	Report the value that defines the provider's service setting. **EXAMPLE:** 1 = Facility	Required when PV034 = 0, 1, 2, 3, 4, or 5	98%	A0
								Code	***Description***			
								1	Facility			
								2	Doctors office			
								3	Clinic			
								4	Walk in Clinic			
								5	Laboratory			
								0	Other			
PV	61	PV 061	Prescribing Provider	11/8/12	Lookup Table - Integer	tlkpFlagIndicators	int[1]	Indicator - Prescribing Authority	Report the value that defines the element. **EXAMPLE:** 1 = Yes, provider has prescribing privileges for pharmaceuticals or DME.	All	100%	A2
								Value	***Description***			
								1	Yes			
								2	No			
								3	Unknown			
								4	Other			
								5	Not Applicable			

PV	62	PV 062	Provider Affiliation Start Date	11/8/12	Full Date - Integer	Century Year Month Day - CCYYMMDD	int[8]	Provider Start Date	Report the start date of provider's relationship with parent entity / group in PV056 (Provider Affiliation) in CCYYMMDD Format. Providers that are self-affiliated (or no affiliation) should have the same value reported here as in PV037.	All	98%	A0
PV	63	PV 063	Provider Affiliation End Date	11/8/12	Full Date - Integer	Century Year Month Day - CCYYMMDD	int[8]	Provider End Date	Report the end date of provider's relationship with parent entity / group in PV056 (Provider Affiliation) in CCYYMMDD Format. Do not report any value here if the affiliation is still active, or if there is no known affiliation in PV056. Self-affiliations should report the same value here as in PV038.	All	98%	B
PV	64	PV 064	PPO Indicator	11/8/12	Lookup Table - Integer	tlkpFlagIndicators	int[1]	Indicator - Provider PPO Contract	Report the value that defines the element. **EXAMPLE:** 1 = Yes, provider is a contracted network provider.	Required when PV034 = 0, 1, 2, 3, 4, or 5	100%	A0

Value	***Description***
1	Yes
2	No
3	Unknown
4	Other
5	Not Applicable

PV	65	PV 065	TME - Non-Claims Payments: Incentive Programs	11/8/12	Integer	Currency	±varchar[10]	Total Medical Expense / Relative Price Reporting Requirement	Report the total dollars paid to this provider for participating in any Incentive Programs created / maintained by the insurance carrier. Incentive Programs include: All payments made to providers for achievement in specific pre-defined goals for quality, cost reduction, or infrastructure development. Examples include, but are not limited to, pay-for-performance payments, performance bonuses, and EMR/HIT adoption incentive payments. Report the total dollar amount for the calendar year as of the filing date. For example, May reporting should include the cumulative amount paid for January + February + March + April, etc... Report 0 when if non-payment applies but was not issued. Value may be either positive or negative. Do not report any value if category does not apply to provider. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. **EXAMPLE:** 150.00 is reported as 15000; 150.70 is reported as 15070	Required when Submitter is identified as a TME/RP Submitter	100%	A2

PV	66	PV 066	TME - Non-Claims Payments: Risk Settlements	11/8/12	Integer	Currency	±varchar[10]	Total Medical Expense / Relative Price Reporting Requirement	Report the total dollars paid to this provider for participating in any Risk Settlements created / maintained by the insurance carrier. Risk Settlements include: All payments made to providers as a reconciliation of payments made (risk settlements) and payments made not on the basis of claims (capitated amount). Amounts reported as Capitation and Risk Settlement should not include any incentive or performance bonuses. Report the total dollar amount for the calendar year as of the filing date. For example, May reporting should include the cumulative amount paid for January + February + March + April, etc... Report 0 when if non-payment applies but was not issued. Value may be either positive or negative. Do not report any value if category does not apply to provider. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. **EXAMPLE:** 150.00 is reported as 15000; 150.70 is reported as 15070	Required when Submitter is identified as a TME/RP Submitter	100%	A2
PV	67	PV 067	TME - Non-Claims Payments: Care Management	11/8/12	Integer	Currency	±varchar[10]	Total Medical Expense / Relative Price Reporting Requirement	Report the total dollars paid to this provider for participating in any Care Management Programs created / maintained by the insurance carrier. Care Management includes: All payments made to providers for providing care management, utilization review, discharge planning, and other care management programs. Report the total dollar amount for the calendar year as of the filing date. For example, May reporting should include the cumulative amount paid for January + February + March + April, etc... Report 0 when if non-payment applies but was not issued.	Required when Submitter is identified as a TME/RP Submitter	100%	A2

									Value may be either positive or negative. Do not report any value if category does not apply to provider. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. **EXAMPLE:** 150.00 is reported as 15000; 150.70 is reported as 15070			
PV	68	PV 068	TME - Non-Claims Payments: Other	11/8/12	Integer	Currency	±varchar[10]	Total Medical Expense / Relative Price Reporting Requirement	Report the total dollars paid to this provider for participating in any other unidentified program created / maintained by the insurance carrier. Other Payments include: All other payments made pursuant to the payer's contract with a provider that were not made on the basis of a claim for medical services and that cannot be properly classified elsewhere. This may include governmental payer shortfall payments, grants, or other surplus payments. Only payments made to providers are to be reported. Payments to government entities, such as the Health Safety Net Surcharge, may not be included in any category. Report the total dollar amount for the calendar year as of the filing date. For example, May reporting should include the cumulative amount paid for January + February + March + April, etc... Report 0 when if non-payment applies but was not issued. Value may be either positive or negative. Do not report any value if category does not apply to provider. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. **EXAMPLE:** 150.00 is reported as 15000; 150.70 is reported as 15070	Required when Submitter is identified as a TME/RP Submitter	100%	A2

PV	69	PV 069	TME - Non-Claims Payments: Total	11/8/12	Integer	Currency	±varchar[10]	Total Medical Expense / Relative Price Reporting Requirement	Report the sum of all dollars paid to this provider for participating in any Non-Claims Payment Programs created / maintained by the insurance carrier. Report the sum of the total dollar amount for the calendar year as of the filing date. For example, May reporting should include the cumulative amount paid for January + February + March + April, etc... Report 0 when if non-payment applies but was not issued. Value may be either positive or negative. Do not report any value if category does not apply to provider. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. **EXAMPLE:** 150.00 is reported as 15000; 150.70 is reported as 15070.	Required when Submitter is identified as a TME/RP Submitter	100%	A2
PV	70	PV 070	TME - Non-Claims Payments: Date	11/8/12	Full Date - Integer	Century Year Month Day - CCYYMMDD	int[8]	Total Medical Expense / Relative Price Reporting Requirement	Report the paid-through date of Non-Claims Payment to the provider in CCYYMMDD Format. **EXAMPLE:** Non-Claims Payments Date through the end of April of 2012 is reported as 20120430	Required when Submitter is identified as a TME/RP Submitter	100%	A2
PV	71	PV 899	Record Type	6/24/10	Text	ID File	char[2]	File Type Identifier	Report **PV** here. This validates the type of file and the data contained within the file. This must match HD004	All	100%	A0
TR-PV	1	TR 001	Record Type	6/24/10	Text	ID Record	char[2]	Trailer Record Identifier	Report **TR** here. Indicates the end of the data file	Mandatory	100%	TM
TR-PV	2	TR 002	Submitter	11/8/12	Integer	ID Submitter	varchar[6]	Trailer Submitter / Carrier ID defined by CHIA	Report the Unique Submitter ID as defined by CHIA here. This must match the Submitter ID reported in HD002	Mandatory	100%	TM
TR-PV	3	TR 003	National Plan ID	11/8/12	Integer	ID Nat'l PlanID	int[10]	CMS National Plan Identification Number (PlanID)	Do not report any value here until National PlanID is fully implemented. This is a unique identifier as outlined by Centers for Medicare and Medicaid Services (CMS) for Plans or Sub plans	Situational	0%	TS

TR-PV	4	TR 004	Type of File	6/24/10	Text	ID File	char[2]	Validates the file type defined in HD004.	Report **PV** here. This must match the File Type reported in HD004	Mandatory	100%	TM
TR-PV	5	TR 005	Period Beginning Date	6/24/10	Date Period - Integer	Century Year Month - CCYYMM	int[6]	Trailer Period Start Date	Report the Year and Month of the reported submission period in CCYYMM format. This date period must match the date period reported in HD005 and HD006	Mandatory	100%	TM
TR-PV	6	TR 006	Period Ending Date	6/24/10	Date Period - Integer	Century Year Month - CCYYMM	int[6]	Trailer Period Ending Date	Report the Year and Month of the reporting submission period in CCYYMM format. This date period must match the date period reported in TR005 and HD005 and HD006	Mandatory	100%	TM
TR-PV	7	TR 007	Date Processed	6/24/10	Full Date - Integer	Century Year Month Day - CCYYMMDD	int[8]	Trailer Processed Date	Report the full date that the submission was compiled by the submitter in CCYYMMDD Format.	Mandatory	100%	TM

Appendix – External Code Sources

1. Countries

American National Standards Institute
http://webstore.ansi.org/SdoInfo.aspx?sdoid=39&source=iso_member_body

PV020

2. States, Zip Codes and Other Areas of the US

U.S. Postal Service
https://www.usps.com/

PV019	PV021	PV026	PV028

3. National Provider Identifiers

National Plan & Provider Enumeration System
https://nppes.cms.hhs.gov/NPPES/

PV039	PV040

4. Provider Specialties

OptumInsight Specialty Codes
http://www.optuminsight.com/transparency/etg-links/episode-treatment-groups/

PV030	PV042	PV043	PV044

5. Health Care Provider Taxonomy

Washington Publishing Company
http://www.wpc-edi.com/reference/

PV022

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Center for Health Information and Analysis

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